WCB Workers Compensation Board of Manitoba

To report your claim faster, please CALL:
954-4100 (Toll-free 1-800-362-3340)

or fax this form to:
954-4999 (Toll-free 1-877-872-3804)
333 Broadway • Winnipeg R3C 4W3

WORKER INCIDENT REPORT

Claim No. **3**

Worker Information

Last Name			First Name	
Address			City	
Province	Postal Code	Telephone No. ( )	Date of Birth DD / MM / YYYY	PHIN ___-___-___
Social Insurance Number	Male ☐ Female ☐		Job Title	

Employer Information

Business Name		Address (include Branch where applicable)	
City	Province	Postal Code	Telephone No. ( )

Incident Details

Date of Incident DD / MM / YYYY	Area(s) of Injury
Date Reported to Employer DD / MM / YYYY	Name and position of person to whom incident was reported.

Please describe the incident in as much detail as possible. (Use separate sheet if necessary. If applicable, identify any witnesses.)

City and province where incident occurred.

Did the incident occur on your employer's premises? ☐ yes ☐ no If no, specify name and address of premises where incident happened.

Name and Address of Doctor(s) and/or Hospital(s) that Provided Treatment (Attach separate sheet if necessary)

Name	Address	Date of Visit DD / MM / YYYY
Name	Address	Date of Visit DD / MM / YYYY

Time Loss & Wages (Only complete this section if you have missed time from work beyond the date of the incident)

What was the last day and hour you worked following the incident? DD / MM / YYYY at HOUR ☐ AM ☐ PM

Have you returned to work? ☐ yes ☐ no If yes, when? DD / MM / YYYY at HOUR ☐ AM ☐ PM

Were you paid wages by your employer while you were off work? ☐ yes ☐ no	Do you have other sources of employment income? ☐ yes ☐ no
How many hours do you work per week? If it varies, please describe.	What are your regular days off? If it varies, please describe.
What is your current hourly wage? $	What are your regular gross earnings? (Specify weekly, bi-weekly, etc.) $
What is your marital status? ☐ Single ☐ Common-law ☐ Married ☐ Separated ☐ Divorced	If married/common-law, is your spouse/partner working? ☐ yes ☐ no

Are you personally allowed to claim a deduction on your current year Income Tax Return for:

- Dependant children age 18 years or younger? ☐ yes ☐ no If yes, how many dependants? _____
- Disabled dependants age 18 years or older? ☐ yes ☐ no If yes, how many dependants? _____
- Child care expenses? ☐ yes ☐ no If yes, estimate total deduction for current tax year $ _____
- Child support payments? ☐ yes ☐ no If yes, state monthly amount $ _____ Total for the year $ _____
- Spousal support payments? ☐ yes ☐ no If yes, state monthly amount $ _____ Total for the year $ _____

Have you applied for income from other sources? (e.g. EI, CPP, Social Insurance, Co. Disability Plan, etc.) ☐ yes ☐ no If yes, please describe.

Worker's Name	Claim No.	3

Coverage

Was anyone not employed by your employer involved in the incident? ☐ yes ☐ no	If yes, give name and address.	
Are you a partner, director or sole proprietor of the company? ☐ yes ☐ no		
Are you a sub-contractor? ☐ yes ☐ no	If yes, specify: ☐ construction ☐ logging	(Complete appropriate sections below)
Are you an owner operator? ☐ yes ☐ no	If yes, specify: ☐ courier ☐ trucking ☐ towing	(Complete appropriate sections below)

Please answer these questions if the incident occurred between Jan. 1, 1992 and Dec. 31, 2005

Are you a member of the family of your employer (or if the employer is a corporation, a family member of the director of the corporation)? ☐ yes ☐ no

If yes, do you reside with the employer or director? ☐ yes ☐ no

Farming:

Are you related to the farm owner? ☐ yes ☐ no

Sub-Contractor or Owner Operator: (only complete if you are a sub-contractor or owner operator)

Is your employer covering you under their WCB coverage? ☐ yes ☐ no		If no, are you registered with WCB? ☐ yes ☐ no	
Do you work in a partnership? ☐ yes ☐ no		Do you employ other workers? ☐ yes ☐ no	

Sub-Contractor in Construction

Do you supply any materials or equipment? ☐ yes ☐ no	If yes, please specify.

Sub-Contractor in Logging

Do you supply any materials or equipment? ☐ yes ☐ no	If yes, please specify.
Were you cutting on the firm's timber sale, timber permit or sawmill license? ☐ yes ☐ no	If no, on whose timber sale, timber permit or sawmill license were you cutting?

Owner Operator is a Courier

What is the gross vehicle weight? (This can be obtained from the Autopac registration)

Owner Operator in Trucking

Do you haul within a 16 km radius of the city or town in which the home terminal is located? ☐ yes ☐ no		Are you a long distance driver? ☐ yes ☐ no	
Do you provide a vehicle? ☐ yes ☐ no		If yes, how many vehicles do you provide?	

I understand that under *The Workers Compensation Act* the WCB can collect information about me to adjudicate and manage my claim and that information from my claim may be disclosed to my employer or employer representative for WCB program purposes, or may be released to others as authorized by legislation, including *The Workers Compensation Act*, *The Personal Health Information Act* and *The Freedom of Information and Protection of Privacy Act*. The information collected may be used to conduct WCB evaluations and surveys.

If you have any questions regarding the collection, use or disclosure of information on your claim, please contact the WCB's Access and Privacy Officer at 954-4557 or toll free at 1-800-362-3340 extension 4557.

Release for Medical Information

I authorize persons in possession of medical and other information that the WCB determines relevant to this claim to release same to the WCB upon request.

Release for Income Information from Canada Customs and Revenue Agency

This is your authorization to provide the Workers Compensation Board of Manitoba with copies of my complete income tax return(s) and other taxpayer information including all supporting information slips, schedules and financial statements. The information will be used:

(1) to assist in establishing my net average earnings and

(2) to determine and verify eligibility for benefits under the Workers Compensation Act.

This authorization is valid for the two taxation years prior to the year it was signed, the year it was signed, and each following taxation year where benefits are provided.

Signature of Worker	Date
X	DD / MM / YYYY